Statement of Health	
Employee Name	Date
Date of Birth	Sex
Family Physician Name	Physician Phone
Have you had any spains, strains, or pulled muscles in the past 12 months?	Have you been hospitalized in the past 12 months?
List any allergies:	Do you have sesonal allergies that require medication?
Are you currently taking any medications?	Do you cough, wheeze or have trouble breathing after activity?
Do you use proctective equipment (knee brace, back brace, etc.)?	Have you had problems with you vision? Do you wear glasses or contacts?
Are you free from communicable diseases?	Do you have any physical limitations or restrictions that would prevent you from clinical activities such as moving, lifting or transfering patients?
I certify that all information provided above is true and correct to the best of my knowledge. **Signature** ____ **Date** _______________________	
Physical Information	
Height	Weight
Pulse	Blood Pressure
Medical Evaluation: Normal or Abnormal Findings	
Eyes/Ears/Nose/Throat	Neck
Back	Shoulder/Arm
Heart	Elbow/Forearm
Pulse	Wrist/Hand
Lungs	Hip/Thigh
Abdomen	Knee/Leg
Skin	Ankle/Foot
Evaluation provided by ____ **Date** _______________________	

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PPD (Mantoux) TB Form
Name:
Testing Location:
Date placed:
Site:
Lot #:
Signature (Adminstrated by) ____ Date _______________________
Date Read:
Induration (noted in mm):
Result:
Signature (Adminstrated by) ____ Date _______________________
In order for this document to be valid, all sections must be completed

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